

provider shall include the testing entity's basic fee charged to the facility and other costs associated with competency testing, to the extent allowable under ARM 37.40.345. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1993 MAR p. 1385, Eff. 7/1/93; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1997 MAR p. 474, Eff. 3/11/97; AMD, 1998 MAR p. 1749, Eff. 6/26/98; TRANS, from SRS, 2000 MAR p. 489.)

37.40.323 CALCULATED PROPERTY COST COMPONENT (1) This rule specifies the method used by the department to calculate the property cost component for a specific provider for rate years beginning on or after July 1, 1999. Such property cost component is expressed in dollars and cents per patient day.

(a) Nothing in this rule shall be construed to provide for an automatic rate increase on July 1 of a new rate year. A provider's rate in effect immediately prior to July 1 of a new rate year shall remain in effect throughout the new rate year and subsequent rate years except as provided in ARM 37.40.308.

(2) As used in this rule, the following definitions apply:

(a) "Base period" means the provider's cost reporting period from which property costs are determined for a given year.

(i) Except as otherwise specified in ARM 37.40.326, for rate years beginning on or after July 1, 1999, the base period is the provider's cost report period of at least 6 months with a fiscal year ending between January 1, 1998 and December 31, 1998 inclusive, if available or, if such a cost report has not been timely filed or is otherwise not available, the provider's cost report period of at least 6 months on file with the department before April 1 immediately preceding the rate year.

(b) "Property costs" means allowable patient-related costs for building depreciation, equipment depreciation, capital-related interest, building lease, and equipment leases, subject to the provisions of ARM 37.40.345. Property costs do not include insurance or tax costs.

(c) "Base year per diem property costs" means the provider's total allowable property costs divided by the number of provider's patient days for the base period.

(d) "Property rate cap" means the maximum calculated property cost component which the department will pay to a provider.

(i) For rate years beginning on or after July 1, 1996, the property rate cap is \$11.50.

(e) "1999 property component" means the provider's calculated property component determined for rate year 1999 in accordance with ARM 37.40.323.

(i) For any provider providing nursing facility services in a facility constructed prior to June 30, 1982 and for whom a calculated property component has not been determined by the department in accordance with ARM 37.40.323 for rate year 1998, the 1998 property component shall equal the June 30, 1985 property rate computed for the facility according to the rules in effect as of June 30, 1985 and indexed forward to the 1992 rate year according to the rules in effect for rate year 1992.

(3) For rate years beginning on or after July 1, 1999, the provider's calculated property cost component is as follows:

(a) If the provider's 1999 property component is greater than the provider's base year per diem property costs, then the provider's calculated property cost component is the lesser of the provider's 1999 property component or the property rate cap of \$11.50.

(b) If the provider's base year per diem property costs exceed the provider's 1999 property component by more than \$1.86, then the provider's calculated property cost component is the lesser of the sum of the provider's 1999 property component plus \$1.86, or the property rate cap of \$11.50.

(c) If the provider's base year per diem property costs exceed the provider's 1999 property component by \$1.86 or less, then the provider's calculated property cost component is the lesser of the provider's base year per diem property costs or the property rate cap of \$11.50.

(4) Upon certification of newly constructed beds, a provider's calculated property cost component shall be adjusted to a property cost component calculated as follows:

(a) the adjusted component shall be the lesser of \$11.50 or a blended rate determined by dividing the sum of the product of pre-construction square footage and the provider's July 1 calculated property cost component and the product of the additional constructed square footage and \$11.50, by the total square footage after construction.

(5) Upon completion of an extensive remodeling, a provider's calculated property cost component shall be adjusted to a property cost component calculated as follows:

(a) the adjusted component shall be the lesser of \$11.50 or the existing component plus a per diem amount determined by amortizing 80% of the amount derived by dividing the total allowable remodeling cost by the number of licensed beds after remodeling. Such amount shall be amortized over 360 months at 12% per annum. A per diem amount shall be determined by multiplying the monthly amortization amount by 12 months and dividing the result by 365. (History: Sec. 53-2-201 and 53-6-

113, MCA; IMP, Sec. 53-6-101 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1993 MAR p. 1385, Eff. 7/1/93; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1995 MAR p. 1227, Eff. 7/1/95; AMD, 1996 MAR p. 1698, Eff. 6/21/96; AMD, 1997 MAR p. 1044, Eff. 6/24/97; AMD, 1998 MAR p. 1749, Eff. 6/26/98; AMD, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489; AMD, 2001 MAR p. 1108, Eff. 6/22/01.)

37.40.324 GRANDFATHERED PROPERTY COST COMPONENT (1) For rate years beginning on or after July 1, 1992, all grandfathered property cost components shall be eliminated and no provider shall be entitled to any grandfathering protection. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; TRANS, from SRS, 2000 MAR p. 489.)

37.40.325 CHANGE IN PROVIDER DEFINED (1) Except as provided in (2), a change in provider will be deemed to have occurred if the events described in any one of the following (1)(a) through (d) occurs:

(a) For sole proprietorship providers, a change in provider occurs where the entire sole proprietorship is sold to an unrelated party and a selling proprietor does not retain a right of control over the business.

(b) For partnership providers, a change in provider occurs where:

(i) a new partner acquires an interest in the partnership greater than 50%;

(ii) the new partner is not a related party to either a current partner or a former partner from whom the new partner acquired all or any portion of the new partner's interest; and

(iii) the current or former partners from whom the new partner acquires an interest do not retain a right of control over the partnership arising from the transferred interest.

(c) For corporation providers, a change in provider occurs where stock and the associated stockholder rights representing an interest of more than 50% in the provider's corporation is acquired by an unrelated party.

(d) For all providers, a change in provider occurs where an unrelated party acquires:

(i) the provider's title or interest in the nursing facility or a leasehold interest in the nursing facility; and

(ii) the right to control and manage the business of the nursing facility.

(2) Regardless of the provisions of (1) through (1)(d), a change in provider will not be deemed to have occurred if the

circumstances indicate that:

- (a) a related party will acquire, retain or actually exercise substantial influence over the new entity; or
- (b) the occurrence or transaction is undertaken primarily for the purpose of triggering a change in provider under this rule.

(3) For purposes of this rule:

(a) "Provider" means the business entity having the right to control and manage the business of the nursing facility.

(b) "Related party" means:

(i) a person, including a natural person and a corporation, who is an owner, partner or stockholder in the current provider and who has a direct or indirect interest of 5% or more or a power, whether or not legally enforceable to directly or indirectly influence or direct the actions or policies of the entity;

(ii) A spouse, ancestor, descendant, sibling, uncle, aunt, niece, or nephew of a person described in (3)(b)(i) or a spouse of an ancestor, descendant, sibling, uncle, aunt, niece or nephew of a person described in (3)(b)(i); or

(iii) a sole proprietorship, partnership corporation or other entity in which a person described in (3)(b)(i) or (ii) has a direct or indirect interest of 5% or more or a power, whether or not legally enforceable to directly or indirectly influence or direct the actions or policies of the entity.

(c) "Unrelated party" means a person or entity that is not a related party.

(4) In determining whether a change in provider has occurred within the meaning of this rule, the provisions of federal medicare law, regulation or policy or related caselaw regarding changes in ownership under the medicare program are not applicable.

(5) As required in ARM 37.40.306, a provider must provide the department with 30 days advance written notice of a change in provider and must file a close out cost report, and new providers must enroll in the medicaid program in accordance with applicable requirements.

(6) Any change in provider, corporate or other business ownership structure or operation of the facility that results in a change in federal tax identification number will require a provider to seek a new medicaid provider enrollment. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1995 MAR p. 1227, Eff. 7/1/95; AMD, 1997 MAR p. 76, Eff. 1/17/97; AMD, 1998 MAR p. 1749, Eff. 6/26/98; TRANS, from SRS, 2000 MAR p. 489; AMD, 2000 MAR p. 492, Eff. 2/11/00; AMD, 2001 MAR p. 1108, Eff. 6/22/01.)

37.40.326 INTERIM PER DIEM RATES FOR NEWLY CONSTRUCTED FACILITIES AND NEW PROVIDERS (1) This rule specifies the methodology the department will use to determine the interim per diem rate for in-state providers, other than ICF/MR providers, which as of July 1 of the rate year have not filed with the department a cost report covering a period of at least 6 months participation in the medicaid program in a newly constructed facility or following a change in provider as defined in ARM 37.40.325.

(a) Effective July 1, 2001, the rate paid to new providers that acquire or otherwise assume the operations of an existing nursing facility, that was participating in the medicaid program prior to the transaction, will be paid the price-based reimbursement rate in effect for the prior owner/operator of the facility before the transaction as if no change in provider had occurred. These rates will be adjusted at the start of each state fiscal year in accordance with other provisions of this rule.

(b) Effective July 1, 2001, the rate paid to newly constructed facilities or to facilities participating in the medicaid program for the first time will be the statewide average nursing facility rate under the price-based reimbursement system. The direct care component of the rate will not be adjusted for acuity, until such time as there are 3 or more quarters of medicaid CMI information available at the start of a state fiscal year. Once the CMI information is available the price-based rate will include the acuity adjustment as provided for in other subsections of this rule.

(c) For the rate period July 1, 2000 through June 30, 2001, providers who, as of July 1 of the rate year, have not filed with the department a cost report covering a period of at least 6 months participation in the medicaid program in a newly constructed facility shall have a rate set at the statewide median rate as computed on July 1, 2000 for this rate year in accordance with the rule provisions in ARM 37.40.308. Following a change in provider as provided in ARM 37.40.325, the per diem rate for the new provider shall be set at the previous provider's rate, as if no change in provider had occurred, for the July 1, 2000 through June 30, 2001 transition rate year.

(2) For in-state providers, other than ICF/MR providers, which as of July 1 of the rate year have not filed with the department a cost report covering a period of at least 6 months participation in the medicaid program:

(a) In a newly constructed facility or as a new provider not resulting from a change in provider as defined in ARM 37.40.325, the interim per diem rate shall be the bed-weighted median per diem rate for all nursing facility providers. The

interim rate shall be determined based upon all non-interim provider rates determined by the department and effective as of July 1 of the rate year.

(b) As a new provider resulting from a change in provider as defined in ARM 37.40.325, the new provider's interim rate will be determined in accordance with ARM 37.40.307, 37.40.313, 37.40.314 and 37.40.323, based upon the most recent medicaid cost report covering a period of at least 6 months as filed by the previous provider, and subject to any applicable minimum or maximum rate under the provisions of ARM 37.40.307(3) through (3)(c), as applied to the facility's average per diem rate in effect for the entire previous rate year, as if no change in provider had occurred.

(c) The provider's interim rate shall become effective on the date a provider begins providing medicaid services in a newly constructed facility, as a new provider or on the effective date of a change in provider as defined in ARM 37.40.325.

(d) For changes in provider occurring on or after July 1, 1993, the provider's interim rate shall remain in effect until the provider has filed with the department in accordance with ARM 37.40.346 a complete and accurate cost report covering a period of 6 months participation in the medicaid program in a newly constructed facility, as a new provider or following a change in provider as defined in ARM 37.40.325. Subject to (2)(d)(iv), the interim rate will be adjusted only upon computation of a new interim rate effective July 1 of each rate year, or following a rate adjustment request by a new provider with an interim rate set using a previous provider's cost report, as follows: (i) if a new provider disagrees with the interim rate as determined using the previous provider's cost report, the new provider may request an adjustment of the interim rate in accordance with this section. The rate adjustment request must request an exception to the cost base and include an explanation and documentation with substantive evidence that demonstrates the new provider's costs are and/or will be sufficiently different than the previous provider's specific costs to warrant a rate adjustment in accordance with ARM 37.40.307, 37.40.313, 37.40.314 and 37.40.323; (ii) acceptable documentation to substantiate a different cost base will include:

(A) a budget for operation of the nursing facility through the new provider's fiscal year end, including all cost centers as identified on the department's medicaid cost report worksheet A, with an explanation by cost center of why the costs will be different than the previous provider's; or

(B) actual costs incurred by the new provider to date and projected through the new provider's fiscal year end for all cost centers as identified on the department's medicaid cost report

worksheet A, with an explanation by cost center of why the costs are different than the previous provider's;

(iii) the department will review the documentation submitted by the new provider and will prepare a proforma cost report utilizing the stepdown methodology of cost allocation to arrive at the allowable nursing facility costs. These costs will be considered as current costs of the rate year and as such no inflationary index will be applied. These costs will be used as the new basis for computing the interim rate in accordance with ARM 37.40.307, 37.40.313, 37.40.314 and 37.40.323, and the provider will receive a new interim rate based on such costs, regardless of whether such new interim rate is greater or less than the previous interim rate;

(iv) the new provider's interim rate shall be set as follows:

(A) if the previous provider's rate was less than or equal to the bed-weighted median rate for all facilities for the current year, then the new provider's interim rate shall be the lesser of:

(I) the previous provider's rate adjusted by an amount, if any, determined in accordance with (2)(d)(i) through (iii); or

(II) the bed-weighted median rate for all facilities for the current year.

(B) if the previous provider's rate was greater than the bed-weighted median rate for all providers for the current year, then the new provider's interim rate shall be the previous provider's rate.

(e) After the provider files a complete and accurate cost report as specified in (2)(d), the department will determine a per diem rate based upon such cost report according to the provisions of ARM 37.40.307, 37.40.313, 37.40.314 and 37.40.323. Such per diem rate shall be determined using the period covered by the cost report as the provider's base period. The per diem rate determined in accordance with this subsection shall be effective retroactive to the date the interim rate set under (2) became effective. Any overpayment or underpayment shall be adjusted in accordance with the cost settlement rules specified in ARM 37.40.347.

(3) For purposes of calculating a per diem rate as provided in (2)(e), the following shall apply with respect to patient assessment scores used to calculate the direct nursing personnel cost component:

(a) For providers who have received an interim rate under the provisions of this rule based upon a change in provider, the provider's direct nursing personnel cost component shall be calculated based upon the fiscal year 1999 average patient assessment score for the previous provider, as though no change

in provider had occurred.

(b) For providers who have received an interim rate under the provisions of this rule based upon provision of services in a new facility or as a new provider, the provider's direct nursing personnel cost component shall be calculated based upon the fiscal year 1999 state wide average patient assessment score.

(History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1993 MAR p. 1385, Eff. 7/1/93; AMD, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489; AMD, 2000 MAR p. 492, Eff. 2/11/00; AMD, 2000 MAR p. 1754, Eff. 7/14/00; AMD, 2001 MAR p. 1108, Eff. 6/22/01.)

Rules 27 through 29 reserved

37.40.330 SEPARATELY BILLABLE ITEMS (1) In addition to the amount payable under the provisions of ARM 37.40.307(1) or (5), the department will reimburse nursing facilities located in the state of Montana for the following separately billable items:

- (a) colostomy set;
- (b) ostomy face plate;
- (c) ostomy skin barrier;
- (d) ostomy liquid barrier;
- (e) ostomy skin bond or cement;
- (f) ostomy bag, disposable/closed;
- (g) ostomy bag, reusable or drainable;
- (h) ostomy belt;
- (i) stoma wicks;
- (j) tail closures;
- (k) ostomy skin bond or cement, remover;
- (l) ileostomy set;
- (m) ileal bladder set;
- (n) irrigation set for irrigation of ostomy;
- (o) ostomy lubricant;
- (p) ostomy rings;
- (q) ostomy supplies not otherwise listed;
- (r) ureterostomy set;
- (s) ureterostomy supplies not otherwise listed;
- (t) colon tube;
- (u) disposable colostomy appliances and accessories;
- (v) colostomy irrigation appliance;
- (w) colostomy irrigation accessory;
- (x) colostomy appliance, non-disposable;
- (y) colostomy appliance;
- (z) disposable ileostomy accessory;
- (aa) disposable urostomy bags;
- (ab) piston irrigation set;

- (ac) blood or urine control strips or tablets;
- (ad) dextrostick or glucose test strips;
- (ae) implantable vascular access portal/catheter (venous arterial or peritoneal);
- (af) indwelling catheter, foley type, two-way, teflon;
- (ag) indwelling catheter, foley type, two-way, latex;
- (ah) indwelling catheter, foley type, two-way, latex with teflon coating;
- (ai) indwelling catheter, foley type, two-way, all silicone;
- (aj) indwelling catheter, foley type, two-way, silicone with elastomer coating;
- (ak) indwelling catheter, foley type, three-way, latex or teflon for continuous irrigation;
- (al) external catheter, condom type;
- (am) urinary collection and retention system, drainage bag with tube;
- (an) urinary collection and retention system, leg bag with tube;
- (ao) catheter care kit;
- (ap) catheter insertion tray, without tube and drainage bag;
- (aq) 3-way irrigation set for catheter;
- (ar) urethral catheter;
- (as) catheter miscellaneous supplies;
- (at) urethral catheter with tray;
- (au) caudi-tip catheter;
- (av) male mentor catheter;
- (aw) incontinence clamp;
- (ax) urinary drainage bag;
- (ay) urinary leg bag;
- (az) bedside drainage bag;
- (ba) tracheostomy care kit;
- (bb) nasopharyngeal/tracheal suction kit;
- (bc) oxygen contents, gaseous, per cubic feet;
- (bd) oxygen contents, gaseous, per 100 cubic feet;
- (be) oxygen contents, liquid, per pound;
- (bf) oxygen contents, liquid, per 100 pounds;
- (bg) cannula;
- (bh) tubing, unspecified length, per foot;
- (bi) regulator;
- (bj) mouth piece;
- (bk) stand/rack;
- (bl) face tent;
- (bm) IPPB kit;
- (bn) portable aspirator;
- (bo) connectors;

(bp) face mask;  
(bq) nasal catheter;  
(br) disposable IPPB tubing;  
(bs) disposable humidifier(s);  
(bt) extension hoses;  
(bu) MADA plastic nebulizer with mask and tube;  
(bv) nasal O2 kit;  
(bw) O2 contents, linde reservoir;  
(bx) O2 contents, liberator;  
(by) O2 contents, LV 160;  
(bz) O2 contents, PCU reservoir;  
(ca) O2 contents, GP-45;  
(cb) O2 contents, D cylinder;  
(cc) O2 contents, E cylinder;  
(cd) O2 cylinder contents, GDL-K;  
(ce) cylinder rental, one month;  
(cf) piped in oxygen;  
(cg) oxygen cart for portable tank (purchase);  
(ch) enteral feeding supply kit; syringe (monthly);  
(ci) enteral feeding supply kit; pump fed (monthly);  
(cj) enteral feeding supply kit; gravity fed (monthly);  
(ck) nasal gastric tubing with thin wire or cotton (e.g.,  
travasorb, entriflex, dobb huff, flexiflow, etc.);  
(cl) nasogastric tubing without stylet;  
(cm) stomach tube - levine type;  
(cn) enteral supply kit for prepackaged delivery system  
(monthly);  
(co) nasogastric tubing with or without stylet (e.g.,  
travasorb);  
(cp) enteric feeding set;  
(cq) flex-flo feeding set;  
(cr) nutrition container;  
(cs) IV intercath;  
(ct) IV tubing;  
(cu) IV piggyback tubing;  
(cv) parenteral nutrition supply kit for one month -  
premix;  
(cw) parenteral nutrition supply kit for one month -  
homemix;  
(cx) parenteral nutrition administration kit for one month;  
(cy) enteral supplies not elsewhere classified;  
(cz) parenteral supplies not elsewhere classified;  
(da) feeding syringe;  
(db) gavage feeding set;  
(dc) nutrient solutions for parenteral and enteral  
nutrition therapy when such solutions are the only source of  
nutrition for residents who, because of chronic illness or

trauma, cannot be sustained through oral feeding. Payment for these solutions will be allowed only where the department determines they are medically necessary and appropriate, and authorizes payment before the items are provided to the resident;

(dd) routine nursing supplies used in extraordinary amounts and prior authorized by the department;

(de) effective October 1, 1989, oxygen concentrators and portable oxygen units (cart, E tank and regulators), if prior authorized by the department.

(i) The department will prior authorize oxygen concentrators and portable oxygen units (cart, E tank and regulators) only if:

(A) The provider submits to the department documentation of the cost and useful life of the concentrator or portable oxygen unit, and a copy of the purchase invoice.

(B) The provider maintains a certificate of medical necessity indicating the PO2 level or oxygen saturation level. This certificate of medical necessity must meet or exceed medicare criteria and must be signed and dated by the patient's physician. If this certificate is not available on request of the department or during audit, the department may collect the corresponding payment from the provider as an overpayment in accordance with ARM 37.40.347.

(ii) The provider must attach to its billing claim a copy of the prior authorization form.

(iii) The department's maximum monthly payment rate for oxygen concentrators and portable oxygen units (cart, E tank and regulators) will be the invoice cost of the unit divided by its estimated useful life as determined by the department. The provider is responsible for maintenance costs and operation of the equipment and will not be reimbursed for such costs by the department. Such costs are considered to be covered by the provider's per diem rate.

(2) The department may, in its discretion, pay as a separately billable item, a per diem nursing services increment for services provided to a ventilator dependent resident if the department determines that extraordinary staffing by the facility is medically necessary based upon the resident's needs.

(a) Payment of a per diem nursing services increment under (2) for services provided to a ventilator dependent resident shall be available only if, prior to the provision of services, the increment has been authorized in writing by the department's medicaid services division. Approvals will be effective for 1 month intervals and reapproval must be obtained monthly.

(b) The department may require the provider to submit any appropriate medical and other documentation to support a request for authorization of the increment. Each calendar month, the

provider must submit to the department, together with reporting forms and according to instructions supplied by the department, time records of nursing services provided to the resident during a period of 5 consecutive days. The submitted time records must identify the amount of time care is provided by each type of nursing staff, i.e., licensed and non-licensed.

(c) The increment amount shall be determined by the department as follows. The department shall subtract the facility's current average medicaid case mix index (CMI) used for rate setting determined in accordance with ARM 37.40.320 from the CMI computed for the ventilator dependent resident, determined based upon the current minimum data set (MDS) information for the resident in order to determine the difference in case mix for this resident from the average case mix for all medicaid residents in the facility. The increment shall be determined by the department by multiplying the provider's direct resident care component by the ratio of the resident's CMI to the facility's average medicaid CMI to compute the adjusted rate for the resident. The department will determine the increment for each resident monthly after review of case mix information and 5 consecutive day nursing time documentation review.

(3) The department will reimburse for separately billable items at direct cost, with no indirect charges or mark-up added. For purposes of combined facilities providing these items through the hospital portion of the facility, direct cost will mean invoice price to the hospital with no indirect cost added.

(a) If the items listed in (1)(a) through (1)(de) are also covered by the medicare program and provided to a medicaid recipient who is also a medicare recipient, reimbursement will be limited to the lower of the medicare prevailing charge or the amount allowed under (2). Such items may not be billed to the medicaid program for days of service for which medicare Part A coverage is in effect.

(b) The department will reimburse for separately billable items only for a particular resident, where such items are medically necessary for the resident and have been prescribed by a physician.

(4) Physical, occupational, and speech therapies which are not nursing facility services may be billed separately by the licensed therapist providing the service, subject to department rules applicable to physical therapy, occupational therapy, and speech therapy services.

(a) Maintenance therapy and rehabilitation services within the definition of nursing facility services in ARM 37.40.302, are reimbursed under the per diem rate and may not be billed separately by either the therapist or the provider.

(b) If the therapist is employed by or under contract with

the provider, the provider must bill for services which are not nursing facility services under a separate therapy provider number.

(5) Durable medical equipment and medical supplies which are not nursing facility services and which are intended to treat a unique condition of the recipient which cannot be met by routine nursing care, may be billed separately by the medical supplier in accordance with department rules applicable to such services.

(6) All prescribed medication, including flu shots and time tests, may be billed separately by the pharmacy providing the medication, subject to department rules applicable to outpatient drugs. The nursing facility will bill medicare directly for 100% reimbursement of influenza vaccines and their administration when they are provided to an eligible medicare Part B recipient. Medicaid reimbursement is not available for influenza vaccines and related administration costs for residents that are eligible for medicare Part B.

(7) Nonemergency routine transportation for activities other than those described in ARM 37.40.302(12), may be billed separately in accordance with department rules applicable to such services. Emergency transportation may be billed separately by an ambulance service in accordance with department rules applicable to such services.

(8) The provider of any other medical services or supplies, which are not nursing facility services, provided to a nursing facility resident may be billed by the provider of such services or supplies to the extent allowed under and subject to the provisions of applicable department rules.

(9) The provisions of (3) through (7) apply to all nursing facilities, including intermediate care facilities for the mentally retarded, whether or not located in the state of Montana.

(10) Providers may contract with any qualified person or agency, including home health agencies, to provide nursing facility services. However, except as specifically allowed in these rules, the department will not reimburse the provider for such contracted services in addition to the amounts payable under ARM 37.40.307. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1996 MAR p. 1698, Eff. 6/21/96; AMD, 1998 MAR p. 1749, Eff. 6/26/98; AMD, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489; AMD, 2000 MAR p. 492, Eff. 2/11/00; AMD, 2001 MAR p. 1108, Eff. 6/22/01.)

Extended Rehabilitation Unit (ERU) or Traumatic Brain Injured  
Program (TBI)

### **Program Criteria**

Program developed to meet needs of individuals who are not eligible for acute rehabilitation services but who are still unable to return to independent or home living. The program must provide individualized rehabilitation sustaining therapies and recreational opportunities.

All individuals appropriate for this program must be at Level II (Rancho Scale) or above and be alert to stimuli. The Rancho Scale is a cognitive functioning scale developed by the head injury treatment team at the Rancho Los Amigos Hospital and applies specifically to head injured people following injury.

Individuals referred and admitted to this unit shall demonstrate an ability to recognize, either on their own or with prompting when their behavior is inappropriate. People who demonstrate aggressive behaviors that are potentially dangerous to themselves or others are not appropriate for placement into this program. Those who are elopement risks or require locked units may not be appropriate. If these behaviors develop after admission into the unit the facility reserves the right to discharge to a more appropriate setting or initiate acute intervention.

### **Services to be Provided:**

This facility must provide a continuum of rehabilitation sustaining therapies and activities for post acute TBI survivors to provide quality of life in the least restrictive environment, provide opportunities for TBI survivors to achieve a higher level of independence, offer a peer group to individuals with newly acquired disabilities and supportive services as they learn to adapt and create an positive environment in which behavior intervention and retraining are a part of all programming.

All admissions into the unit will meet nursing facility level of care and will meet the requirements for level I and II criteria for PASARR. Minimum data set requirements and timelines will apply to all admissions into this unit.

Interim rates will be established on July 1, of the rate year from budget information submitted by the provider and an evaluation of the costs of providing care to the individuals in the respective unit. The rate established on July 1, will

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include all nursing facility services as specified in ARM 37.40.307 and all ancillary services specified in ARM 37.40.330 including all feeding solutions, as well as, increased staffing appropriate for the residents in the unit and any costs for physical therapy, speech therapy, occupational therapy, social worker services, psychological services. All of the above indicated costs must be provided within the interim daily rate established for the facility by employees of the facility or under contract with outside providers. The outside providers of these services may not bill medicaid for the provision of these services for any residents occupying a bed in this unit.

Services billable directly to medicaid when provided for residents in this unit and not included in the computation of the daily rate will be dental, pharmacy, physician visits, optometric, podiatry, lab and x-ray and durable medical equipment limited to wheelchairs, adaptations, specialized equipment and repairs.

#### **Reimbursement**

This unit must operate as a distinct part unit from the rest of the nursing facility. Reimbursement levels will be established effective July 1, using an interim payment rate that will be subject to final settlement upon the submission of a cost report of at least six months of operation. Upon submission of a final cost report all costs must meet the allocability criteria and reasonableness established in ARM 37.40.345, 346 and 347.

#### **Settlement of costs will be within a lower limit and an upper limit established as follows:**

If the unit provides the required services for less than the interim rate times 95 percent, the lower limit, the facility will be allowed to maintain all amounts between the lower limit and the actual settled cost per day for provision of the services through the settlement process.

If the unit provides the required services for an allowable cost per day between the interim rate times 95 percent and the interim rate times 105 percent the facility will receive their actual allowable cost per day through the settlement process.

If the unit provides the required services for an allowable cost per day in excess of the interim rate times 105 percent, the upper limit, they will receive 100 percent of their cost up to the upper limit through settlement and any allowable costs in

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